UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM, PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 4:14-cv-3253 JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 204

BUSINESS RECORDS AFFIDAVIT

STATE OF TEXAS

COUNTY OF Travis

RE: Cause Number 3:12-CV-2037;
Stephen McCollum, et al. v. Brad Livingston, et al.
U.S. District Court, Northern District, Dallas Division

BEFORE ME, the undersigned authority, personally appeared John C. West, who, being duly sworn by me, deposed as follows:

"My name is John C. West. I am over 18 years of age, of sound mind, capable of making this affidavit, and have personal knowledge of the facts herein stated:

"I am employed as the General Counsel for the Office of the Inspector General (OIG) – Texas Department of Criminal Justice. I am the custodian of the attached records of the OIG. These records are kept by the OIG in the regular course of business, and it was the regular course of business of the OIG for an employee or representative of the OIG, with knowledge of the act, event, condition, or opinion, recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time or reasonably soon thereafter. The attached record is an exact duplicate of the record on file with the Office of the Inspector General in Criminal Case File No. 2004-1679 concerning Offender Ricky Robertson, TDCJ #1172218 on the death of Offender Robertson on 07/16/2004.

John C. West
General Counsel
Office of the Inspector General

SWORN TO AND SUBSCRIBED before me on this the 26st day of June 2013.

Susan Machutt
Notary Public, State of Texas
My Commission Expires
05/20/2015
Notary Without Bond

NOTARY PUBLIC in and for
The State of Texas
Printed Name: Susan Machutt
My commission expires: May 20, 2015

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL

SUPPLEMENT CRIMINAL CASE REPORT

OFFENSE	CASE #:
Evidence Destruction	2004.1679
LOCATION:	DATE OF OFFENSE:
Hospital Glaveston	08/01/2012
VICTIM:	DATE OF SUPPLEMENT REPORT:
None	10/05/2012

Case Number 2012.03547 was opened as an Information Only Criminal Case to document the final disposition of evidence stored in the OIG Region B Evidence Room for multiple cases listed under this case number.

All evidence pertaining to this particular case number, 2004.1679, which are itemized in Judge Harden's destruction order, was disposed of in accord with the mandates of the order.

The disposition and destruction documents, with original signatures, are filed under Case Number 2012.03547.

INVESTIGATING OFFICER(S)

(1) Curtis M Fogman	#220	October 4,2012	IS FURTHER INVESTIGATIVE ACTION REQUIRED?
	ID#	DATE	
(2)			___ YES _X_ NO
	ID#	DATE	
Leland S	#321	October 04, 2012	
APPROVING SUPERVISOR	ID#	DATE	

CC-0255 (07/2005)

SUMMARY INVESTIGATIVE ACTIVITIES: CASE # 04-1679

DATE & INITIAL	ACTIONS/COMMENTS
12-31-05 LAT	To OLR (Law Review)
1-2-05	Back to Com. Mullen Ref. her notes on 7/6/05. D. Rhodes
1/3/2006 EJM	Mullen. Joe, please refer to my notes, dated 7/6/2005. Need to include a supplemental report to this case to document that the concerns/issues listed were presented + discussed with SPU and case was accepted or declined by SPU. Return case to me with supplement.
1/3/2006 EJM	Mullen. To Records. Return to Region B.
JAN 04 2006 LAT	Back to the field.
1/5/06	Case received. This information concerning the discussion with SPU Phil Hall was detailed in my investigator's notes dated 7/29/05. The notes were placed behind attachments in a secondary folder. A supplement was completed and the notes were moved into this folder. C. Eckert, #175 C Eckert
JAN 05 2006 RECEIVED	Retd. to Ms. Mullen. Joe Nesmith for C. Joe Nesmith
JAN 12 2006 OFFICE OF THE INSPECTOR GENERAL	
Jan. 12 2006 JAN 12 2006 LAT	EJ Mullen. Reviewed. To Records for Closure. Closed

AC-0105 (07/2005)

SUMMARY of ACTIVITIES:

Investigator Name 04-1679

DATE & INITIAL	ACTIONS/COMMENTS
MAR 2 1 2005	Case Audit Joe Nesmith 108 C. Joe Nesmith
4-1-2005	Case forwarded for review C Eckert, #175 C Eckert
APR 0 4 2005	Return to Mr. Mullen. Joe Nesmith 108 C. Joe Nesmith
4-18-05	MET with DR. Linthicum ~~requesting~~ her review of this offender's medical history and medications. Returning case to Capt. Nesmith for Inv. Eckert to gather more information before presenting to the SPU. D. Rhoten
4-25-05	Case received. C. Eckert #175, C. Eckert
6-2-05	Case resubmitted to CJN. C Eckert #175, C. Eckert
6/4/05	Received - present to Cdr. Mullen. Joe Nesmith 108 C. Joe Nesmith
7/6/2005 EJ	Mullen: Case re-reviewed by me and Mr. Rhoten. Per discussion with Mr. Rhoten, we have concerns regarding the factors and circumstances surrounding offender's death; i.e. heat factors; medications; transportation issues; and potential for culpability. Need to discuss these and any other concerns with SPU and present copy of case for prosecutive consideration or declination and ~~Return to Region B~~ document in supplemental report as appropriate. Return to Region B.
07/16/05 RE	To Region B.
7/29/05	Presented copy to SPU Hall. Joe Nesmith 108
NOV 0 8 2005	Checked w/ SPU Hall - he will take it to AG. Joe Nesmith 108
DEC 2 1 2005	TO RECORDS - CLOSURE Joe Nesmith 108 C. Joe Nesmith
RECEIVED	
DEC 2 8 2005	

OFFICE OF THE INSPECTOR GENERAL

AC-0105 (06/2001)

SUMMARY
INVESTIGATIVE ACTIVITIES: CASE# 04-1679TDCJ

DATE & INITIAL	ACTIONS/COMMENTS
07-19-2004 CJA	
	Assigned to Region B
JUL 27 Recd	Case assigned to Investigator CXS.
7-28-04	Cesar Sanchez; case rec.
SEP 25 2004	Reassigned to SDP C. Joe Nesmith
10-20-04	Susan D. Poole
	Spoke to Joe Nesmith concerning this case.
	There are no investigative notes, no photographs of
	deceased - no autopsy -
	Joe instructed me to return this case to Rosharon.
10-21-04	Susan D. Poole
	Submitted to Lt Bowers to be returned to
	J. Nesmith.
11-8-04	Mark T. Bowers Returned to Capt. Nesmith.
NOV 19 2004	Reassigned to CXS
11-22-04	Cesar Sanchez; case rec.
DEC 17 2004	TO RECORDS - CLOSURE C. Joe Nesmith
1-7-05	CASE Received and it is obvious that the investigator
	never investigated this death, only gathered
	documents and placed them in this folder.
	Returned for Inv. Colleen Eckert to investigate
	as her top priority. D. Rhoten
JAN 10 2005	Case rec'd @ Reg B, Rosharon, to Capt. Nesmith. J. SANDLIN
JAN 11 2005	To Inv. Eckert. C. Joe Nesmith 108
1-11-2005	Case received. C Eckert #175 C Eckert

IA-04 (Rev. 08/90)

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
OFFICE OF THE INSPECTOR GENERAL - INVESTIGATIONS DEPARTMENT

CRIMINAL CASE INFORMATION WORKSHEET

(1) 04-1679TDCJ (CRIMINAL CASE NUMBER) (2) HG (UNIT OR LOCATION) (3) 07-16-2004 (DATE OF OFFENSE) (4) 07-19-2004 (DATE CASE OPENED)

(5)

VICTIM, COMPLAINANT, OR WITNESS	V/C/W	TDCJ NUMBER / RANK	DOB	RACE	SEX	SOCIAL SECURITY NUMBER
ROBERTSON, RICKEY	V	01172218	08-21-1966	B	M	[redacted]

(6)

SUSPECT'S NAME	TDCJ NUMBER / RANK	DOB	RACE	SEX	SOCIAL SECURITY NUMBER

(7) ON 7/16/04, AT APPROXIMATELY 12:30 AM, OFFENDER ROBERTSON WAS FOUND UNRESPONSIVE IN HIS CELL. OFFENDER ROBERTSON WAS TAKEN TO THE MEDICAL, WHERE HE HAD 108* TEMPERATURE. OFFENDER WAS LIFE FLIGHTED TO HOSPITAL GALVESTON. AT 3:10 PM, OFFENDER ROBERTSON DIED. PROVISIONAL CAUSE OF DEATH IS OVERDOSE/ SEPSIS (NEUROLEPTIC MALIGANT SYNDROME). LIKELY MANNER OF DEATH IS ACCIDENTAL

SUMMARY OF OFFENSE

(8) EXACT LOCATION OF INCIDENT: HOSPITAL/GALVESTON

(9) VIOLATION OF STATE STATUTE(S): CCP 49.18 DEATH IN CUSTODY

WHICH IS A _____ DEGREE FELONY or A CLASS _____ MISDEMEANOR.

(10) INVESTIGATOR INITIALS: CXS OPENED BY: CJA

REQUEST FOR CASE OPENING

INVESTIGATOR SIGNATURE DATE

TEAM CAPTAIN DATE

COMMANDER DATE

Concur ( )
Non-Concur ( )
Approved ( )
Disapproved ( )

IA-03C (Rev. 07/03)

JUL-19-2004 09:26 FROM:REGION B OIG 281-595-2558 TO:RECORDS P:1

JUL-19-2004 10:25 FROM:OIG DARRINGTON 2815953465+2320 TO:912815952558 P:1/1

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT
Fax Number: (936) 437-6966

CASE OPENING REQUEST

(1) 04-1679 CASE # (Assigned by RECORDS SECTION) (2) Hospital/Galveston UNIT / LOCATION OF OFFENSE / VIOLATION(S) (3) 7/16/2004 DATE OF OFFENSE / VIOLATION(S)

(4) VICTIM, COMPLAINANT, SUSPECT OR WITNESS	VC/SM/W	ID# / RANK	DOB	RACE	SEX	SOCIAL SECURITY #
Robertson, Rickey	V	1172218	8/21/1966	B	M	[redacted]

(5) ALLEGATIONS

On July 16, 2004, at 3:10 p.m., Offender Robertson died ~~at the Hospital/Galveston~~. Provisional cause of death is overdose/sepsis (Neuroleptic Malignant Syndrome). Likely manner of Death is accidental.

On July 16, 2004, approximately 12:30 a.m., Offender was found unresponsive in his cell ~~at the Darrington Unit~~. He was taken to the medical ~~department~~ where ~~it was discovered that~~ he had 108* F ~~in~~ temperature. He was Life Flighted to the hospital in Galveston, Texas, ~~where he later died~~.

(7) VIOLATION OF STATE STATUTE(s) 49.18
DEGREE/CLASS: Death in Custody

or EXECUTIVE DIRECTIVE PD-22, RULE(s) #: N/A

(8) MUOF#: N/A

(9) INV INITIALS: CXS INV EMAIL: CSA6222 OTHER EMAIL:

REQUEST FOR CASE OPENING

Cesar Sanchez	7/16/2004	Joe Yeamith	7/19/04
INVESTIGATOR	DATE	APPROVING SUPERVISOR	DATE

ADDENDUM ATTACHED No

Administrative	–	☐
Criminal	–	☒
IF to Field	–	☐
IF Retention Only	–	☐

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

OFFENSE/INVESTIGATIVE REPORT

OFFENSE:	OR#	CASE #:
Death in Custody Art. 49.18	236065C	04-1679

EXACT LOCATION OCCURRED:	COUNTY IN WHICH OFFENSE OCCURRED / CODE#:	TYPE OF PREMISES:
Hospital/Galveston	Galveston / 04	State Prison

DATE OF OFFENSE:	TIME:	DAY:	DATE REPORTED:	TIME REPORTED:	INVESTIGATED BY:
7/16/2004	3:10 p.m.	Friday	7/16/2004	4:00 P.M.	C. Sanchez, Invest.

PERSON REPORTING OFFENSE:	CONTACT ADDRESS:
Lt. Mickens	Hospital/Galveston

BUSINESS PHONE:	CONTACT PHONE:
409-772-2875	409-772-2875

VICTIM #1 NAME: (LAST, First, MI)	CONTACT ADDRESS:
Robertson, Ricky	Darrington Unit

ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)	SID#	FBI#	CONTACT PHONE:
1172218	06651475	584105DA3	N/A

OCCUPATION	RACE:	SEX:	DOB:	EMPLOYED BY:
Offender	W	Male	8/21/1966	N/A

VICTIM #2 NAME: (LAST, First, MI)	CONTACT ADDRESS:

ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)	SID#	FBI#	CONTACT PHONE:

OCCUPATION	RACE:	SEX:	DOB:	EMPLOYED BY:

SUBJECT #1 NAME: (LAST, First, MI)	CONTACT ADDRESS:	CONTACT PHONE:

RACE:	SEX:	DOB:	HEIGHT:	WEIGHT:	BUILD:	HAIR:	EYES:	COMPLEXION:	ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)

TDCJ EMPLOYEE?	EMPLOYEE JOB TITLE:	EMPLOYEE JOB LOCATION
☐ Yes ☐ No		

TDCJ OFFENDER?	PAROLEE?	SID#	FBI#	ADDITIONAL INFORMATION: (DO NOT USE SS#)
☐ Yes ☐ No	☐ Yes ☐ No			

SUBJECT #2 NAME: (LAST, First, MI)	ADDRESS:

RACE:	SEX:	DOB:	HEIGHT:	WEIGHT:	BUILD:	HAIR:	EYES:	COMPLEXION:	ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)

TDCJ EMPLOYEE?	EMPLOYEE JOB TITLE:	EMPLOYEE JOB LOCATION
☐ Yes ☐ No		

TDCJ OFFENDER?	PAROLEE?	SID#	FBI#	ADDITIONAL INFORMATION: (DO NOT USE SS#)
☒ Yes ☐ No	☐ Yes ☐ No			

DRUG RELATED?	TYPE:	AMOUNT:
☐ Yes ☐ No		

BOOKED?	LOCATION:	BOND:	PROPERTY SIEZED/CONFISICATED?	IF YES, DESCRIBE:
☐ Yes ☒ No			☐ Yes ☒ No	

SUMMARY: ADDENDUM ATTACHED YES

On July 15, 2004, at approximately 9:35 p.m., Offender Robertson was found unresponsive in his cell at the Darrington Unit. He was transported to the medical department where he was found to have 108* F in temperature. He was then Life Flighted to Hospital/Galveston for emergency medical treatment.

[signature]	139	12-13-04
Investigator's Signature	ID#	DATE
[signature] Joe Barnett	108	DEC 1 7 2004
Approving Supervisor's Signature	ID#	DATE

CC-0240 (08/2003) Page 1 of 2

On July 16, 2004, at 3:10 p.m., Offender Robertson expired. Provisional cause of death was established to be overdose/sepsis (Neuroleptic Malignant Syndrome).

Dr. Olano with the Galveston Medical Examiner's office performed an autopsy. The results are as follows:

In summary, this 39-year old man died of complications of severe hyper-thermia and heat stroke. An important contributing fact was a toxic level of tricyclics in serum. The manner of death is accidental.

Investigator's Signature	139 ID#	12-13-04 DATE
Approving Supervisor's Signature	ID#	DATE

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

CRIMINAL CASE REPORT

OFFENSE	CASE #:
Death in Custody 49.18	04-1679TDCJ
LOCATION:	DATE OF OFFENSE:
Hospital/Galveston	07-16-2004
VICTIM:	DATE OF SUPPLEMENT REPORT:
Robertson, Rickey, TDCJ# 1172218	12-13-2004

CASE NARRATIVE:

Offender Rickey L. Robertson, TDCJ# 1172218, arrived to the Texas Department of Criminal Justice-Institutional Division on June 25, 2003. Robertson was serving a 3-year sentence for Deadly Conduct. Offender Robertson was assigned to the Darrington Unit.

Offender Robertson had a history of bipolar disorder, borderline personality disorder and substance abuse. Robertson was taking the following medications: Lithium 600 mg, Chloropromazine 100 mg, benztropin 2 mg, amantadine 100 mg, and nortryptyline 75 mg.

On July 15, 2004, at approximately 9:35 p.m., Robertson was found unresponsive in H-line, 2-row, 3-cell. Robertson was placed on the floor and examined by medical staff. The nurse instructed the officers to take Robertson to the unit infirmary. Sergeant Michael W. Stephens, Officer Michael D. Knight Jr., Officer Fidel Gallegos and Officer Everest Mbonu carried Robertson out of the cell. They placed him on a medical board, and took him down the stairs where Robertson was transferred to a gurney. Robertson was transported to the medical department. Robertson's temperature was documented at 108* degrees and his vital signs showed him with very low blood pressure. Robertson was sent via life-flight to UTMB-Galveston, Texas, where his condition continued to deteriorate.

On July 16, 2004, Dr. Movva placed Robertson on the critical list and the next of kin was notified of his deteriorating condition. The family of Robertson agreed on a "do not resuscitate" decision as well as withholding all medical intervention.

On July 16, 2004, at 3:05 p.m., Offender Robertson expired.

Dr. Juan P. Olano with the Galveston medical examiner's office conducted an autopsy. The results are as follows:

INVESTIGATING OFFICER(S)	IS FURTHER ACTION REQUIRED?	STATUS OF CASE – Date 12-13-04
(1) [signature] 139	___ YES ✓ NO	___ U – Unfounded ___ I – INACTIVE Investigation Suspended
(2)		___ P – Cleared by Arrest ✓ A – CLD/ADMN Closed Administratively
APPROVING SUPERVISOR ID#		___ E – Cleared by Exception

CC-0260 (08/2003)

In summary, this 39-year old man died of complications of severe hyper-thermia and heat stroke. An important contributing factor was a toxic level of tricyclics in serum. The manner of death is accidental.

VICTIM(S) STATEMENT:
Robertson, Rickey L., TDCJ# 1172218, Offender, Darrington Unit: Deceased.

SUSPECT(S) STATEMENT:
None.

WITNESSES:
Mbonu, Everest, Correctional Officer, Darrington Unit: He can testify that he was the officer assigned to H-line. He can testify that two offenders notified him of Robertson's condition and he responded by calling for assistance. He can testify that he assisted in placing Robertson on the gurney.

Gallegos, Fidel, Correctional Officer, Darrington Unit: He can testify that responded to H-line where he observed Offender Robertson toward the desk. He can testify that he assisted in placing the offender on the floor. He can testify that he assisted in placing the offender on the gurney. He can testify that the nurse strapped Robertson on the gurney and Robertson was carried away.

Knight, Michael, D. Jr., Correctional Officer, Darrington Unit: He can testify that he observed the offender sitting on the far end of the cubicle leaning over the desk. He can testify that he assisted in placing the offender on the floor. He can testify that assisted in carrying him down the stairs to the medical department.

EVIDENCE:

None.

Investigator's Signature 139 ID# 12-13-04 DATE

ATTACHMENTS:

1. Investigative Notes
2. Custodial Death report.
3. Investigator's report of Custodial Death.
4. Offender Robertson's clinic notes.
5. TDCJ-Autopsy Order.
6. Shift Lieutenant's Report–Offender Death Notification.
7. Offender Death Notification Work Sheet.
8. Chaplain's letter to the family.
9. Serious/Critical Notification Report.
10. Copy of Offender Robertson's travel card.
11. EAC report of Darrington Unit.
12. Final Autopsy report.
13. Pictures of deceased taken by pathologist.

CXS

Investigator's Signature	ID#	DATE
	139	12-13-04
Approving Supervisor's Signature	ID#	DATE

11/4/2005

Joe, Something is seriously wrong with this case. [redacted]

(1) Investigative notes are incomplete & poorly written; insufficiently documented; why is first entry 11/22/04 when death occurred 7/16/04?

(2) Did any OIG Investigator respond to unit or HG on date of incident? HG

(3) Narrative does not indicate what OIG did to investigate this questionable death.

(4) Conflicting manners of death - natural & accidental - are not fully explained in report.

(5) What was temperature in cell on date of incident?

(6) Was Robertson alone when he expired?

(7) Why was case reassigned to Susan Poole & then reassigned to Sanchez? [Poole was with us about 3 months]

(8) What investigative activity occurred between date of incident & Sept. 25 and from Sept. 25 - Nov. 22?

(9) Why no pictures taken by OIG of scene & body?

(10) No explanation of how medications were distributed to Robertson; did he have any meds in his cell; what was each med taken for? Were they dispensed appropriately?

(11) The cause + manner of death are not clear. More explanation needed. How was death accidental? Overdose?

(12) Who actually found the offender + reported his unresponsiveness?

(13) Single cell - report does not say.

(14) Offender supposedly had just returned to DA from Jester 4 on the date of incident. This is not mentioned in OIG report.

(15) Who, if anyone, did OIG interview during this investigation?

Did TDCJ cause the death?
If so who is the persons? persons?

1. Offense Report
   Date of offense = 7-16-04
   Date of Report = 7-16-04
   Summary says: On July 15, '04 the offender was found unresponsive in his cell.

2. No medical records in the case.

3. TDCJ has a strict Heat prevention policy with lengthy written instructions for staff every spring.
   What policies, if any, were violated on this offender who was taking psych. meds? none

4. There is no time line for the chain of events and responses during this emergency.

5. Again, no medical charts to document medical response to this offender's medical problem.

6. Was any CPR started at the cell? no
   If not when - what time and by whom?

7. Was offender ever cooled down with ice. YES - in medical by Phaster.

8. When did the life flight get there? When did it leave When did it arrive at hospital?

9. Says Dr. Mouva placed offender on the critical list the next day. Where are the hospital and Dr. Mouva's medical reports on this offender? we in

10. Says on July 16th at 3:05pm offender expired. Who pronounced him deceased? Dr.

11. Says Dr. Olmo did autopsy - Does not say (when)

12 - witnesses

Mbonu - 2 officers notified him of vic. cond. is he "responded"

Gallegos - Assisted after "Responding"

Knight - Saw vic. sitting.

INV. Notes.

13. Sgt
11-22-04 Received case Summary —
7-19-0[illegible] HE opened the case

A Review of my planner disclosed that he responded to Hosp. Galv. & completed the paperwork.

No Record of pictures

14. IOC from Lt. Haley.

~~[illegible]~~ Sgt Sanchez had unit "search offenders cell & photograph it"

15. Exc Report repeats the same as 14

16. RAC stop temp. ~~readings~~ were taken on cell Block — when? (2:00 AM) Stop were normal — what were they? who took them?

17. TDx shows negative for All of his meds except Notriptyline — what was the level?

* Sanchez Dep:
All meds on record were within NORMAL PRESCRIPTION RANGES for age & weight —

TOO MANY other problems to even List —

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL

SUPPLEMENT CRIMINAL CASE REPORT

OFFENSE	CASE #:
Death in Custody	04-1679
LOCATION:	DATE OF OFFENSE:
UTMB Galveston	7/16/2004
VICTIM:	DATE OF SUPPLEMENT REPORT:
Robertson, Ricky TDCJ # 1172218	1/5/2006

On July 21, 2005, I met with SPU Phil Hall and presented this case to him. I explained that the offender died in Galveston, but any act of negligence would have occurred either at the Jester IV Unit or at the Darrington Unit. Robertson was pronounced deceased in Galveston County. Mr. Hall reviewed the case and stated that he did not see any criminal offense on the part of any employee. I did voice the concerns of Ms. Mullen and Mr. Rhoten concerning the transportation, medication, and housing of the decedent. Mr. Hall still stated that he saw no criminal violations. Mr. Hall requested that I contact Galveston County Assistant District Attorney Mohamed Ibrahim.

On July 25, 2005, I contact Mr. Ibrahim and left a message for him to call me. I spoke to Mr. Ibrahim and provided him with the details of the case. Mr. Ibrahim concurred with Mr. Hall and deferred the case to Mr. Hall for his disposition.

July 26, 2005, I discussed this case again with Mr. Hall and gave him Mr. Ibrahim's response. Mr. Hall stated that even though there was no criminal offense he would present the case to the Brazoria County grand jury. Mr. Hall requested a copy of the case.

On July 29, 2005, the original case folder was submitted after a copy was made for Mr. Hall and the copy was provided to Mr. Hall.

This information was provided in my investigator's notes dated July 29, 2005.

On December 12, 2005, Mr. Hall declined the case and stated that there was no further criminal action needed by his office. Mr. Hall made this decision after the case was discussed with Brazoria County First Assistant District Attorney Keith Allen.

INVESTIGATING OFFICER(S)	ID#	DATE	IS FURTHER INVESTIGATIVE ACTION REQUIRED?
(1) C Eckert	175	1/5/06	
(2)	ID#	DATE	___ YES ✓ NO
Joe Reardon	108	1/5/06	
APPROVING SUPERVISOR	ID#	DATE	

CC-0255 (02/2005)

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DIVISION

CRIMINAL CASE TRACKING DISPOSITION

Case #: 04-1679 Offense Date: 7-16-2004
Unit of Occurrence: Jester IV / Darrington OIG Investigator: Colleen Eckert

To:	Please Return To:
Phil Hall Brazoria County District Attorney's Office 111 East Locust Angleton, Texas 77515	Joe Nesmith Region III Captain 1400 FM 655 Rosharon, Texas 77583

Defendant Name: Multiple Defendants ☐ - deceased
Robertson, Ricky
Last First MI

Race	Sex	Age	Date of Birth
B	M	37	8/21/1966

TDCJ Identification # 1172218 SID #: 06651475

CHARGES FILED

1. Offender Death in Custody CCP. 49.18
2.
3.

Presented to Prosecutor / District Attorney

Date: 12/12/05 ☐ Accepted ☒ Declined
By: [signature] (Prosecutor's/D.A.'s Signature)
PHILIP HALL (Prosecutor's/D.A.'s Printed Name)
☐ D.A. ☒ SPU County: Brazoria
Plea: ☐ Nolo Contendere ☐ Not Guilty ☐ Guilty
☐ Dismissed Reason:
Remarks: 12/8/05 Met 1st Assistant Kathy Aller - No further criminal action needed by this office

Presented to Grand Jury

Date: ☐ True Billed ☐ No Billed Cause #
Remarks:

Trial Result / Disposition

Date:
Plea: ☐ Nolo Contendere ☐ Not Guilty ☐ Guilty ☐ Dismissed Reason:
Remarks:

Final Charges

☐ Same ☐ Reduced to: ☐ Other

1.
2.
3.

Years TDCJ and/or Fine: $ Probation:
☐ Concurrent ☐ Consecutive

Remarks:

RECEIVED
JUL 28 2005

TDCJ – Office of the Inspector General	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

7/11/2005 10:00 a.m.
I spoke to Ms. Craven at the SPU office that Mr. Hall was on vacation and would only be returning on 7/14/2005, and then would be back on vacation. C. Eckert, # 175

7/18/2005 10:00 a.m.
Spoke to Ms. Craven at the SPU office. She stated that Mr. Hall would be back on 7/20/2005. C. Eckert, #175

7/20/2005 10:30 a.m.
I called Mr. Hall and Ms. Craven and left messages on both of their answering machines about a possible meeting on 7/21/2005. C. Eckert, # 175

7/21/2005 9:15 a.m.
Ms. Craven called and stated that Mr. Hall would be available at 10:00 a.m., C. Eckert, # 175

7/21/2005 10:15 a.m.
I met with SPU Phil Hall and presented this case to him. I explained that the offender died in Galveston, but any act of negligence would have occurred either at the Jester IV Unit or at the Darrington Unit. Mr. Hall reviewed the case and stated that he did not see any criminal offense on the part of any employee. I did voice the concerns of Ms. Mullen and Mr. Rhoten concerning the transportation, medication, and housing of the decedent. Mr. Hall still stated that he saw no criminal violations. Mr. Hall requested that I contact Galveston County DA Mohamed Ibrahim Robertson was pronounced deceased in Galveston County. C. Eckert, # 175

7/25/2005 1:30 p.m
I contact Mr. Ibrahim and left a message for him to call me. C. Eckert, # 175

7/25/2005 4:20 p.m.
I spoke to Mr. Ibrahim and provided him with the details of the case. Mr. Ibrahim concurred with Mr. Hall and deferred the case to Mr. Hall for his disposition. C. Eckert, # 175

7/26/2005 1:00 p.m.
I discussed this case again with Mr. Hall and gave him Mr. Ibrahim's response. Mr. Hall stated that even though there was on criminal offense he would present the case to the Brazoria County grand jury. Mr. Hall requested a copy of the case. C. Eckert, # 175

INVESTIGATING OFFICER

(1) C Eckert 175 7/29/05
ID# DATE

CC-00045 (02/2005)

TDCJ – Office of the Inspector General	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

7/29/2005 9:20 a.m.
The original case folder was submitted after a copy was made for Mr. Hall. C. Eckert, # 175
7/29/2005 1:00 p.m.
A copy of this case was provided to Mr. Hall. C. Eckert, # 175

INVESTIGATING OFFICER

(1) C Eckert 175 7/29/05
ID# DATE

CC-00045 (02/2005)

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

OFFENSE/INVESTIGATIVE REPORT

OFFENSE:						ORI#	CASE #:
Death in Custody Art. 49.18						236065C	04-1679
EXACT LOCATION OCCURRED:				COUNTY IN WHICH OFFENSE OCCURRED / CODE#:			TYPE OF PREMISES:
Hospital Galveston				Galveston / 84			State Prison
DATE OF OFFENSE:	TIME:	DAY:	DATE REPORTED:		TIME REPORTED:	INVESTIGATED BY:	
7/16/2004	3:10 p.m.	Friday	7/16/2004		4:00 p.m.	C. Eckert	
PERSON REPORTING OFFENSE:			CONTACT ADDRESS:				
Lieutenant Stacy Mickens			Hospital Galveston				
BUSINESS PHONE:			CONTACT PHONE:				
409-772-2875			409-772-2875				
VICTIM #1 NAME: (LAST, First, MI)			CONTACT ADDRESS:				
Robertson, Ricky			Hospital Galveston				
ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)		SID#		FBI#		CONTACT PHONE:	
1172218		06651475		584105DA3		N/A	
OCCUPATION		RACE:	SEX:	DOB:		EMPLOYED BY:	
Offender		W	Male	8/21/1966		N/A	
VICTIM #2 NAME: (LAST, First, MI)			CONTACT ADDRESS:				
ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)		SID#		FBI#		CONTACT PHONE:	
OCCUPATION		RACE:	SEX:	DOB:		EMPLOYED BY:	
SUBJECT #1 NAME: (LAST, First, MI)			CONTACT ADDRESS:				CONTACT PHONE:
RACE:	SEX:	DOB:	HEIGHT:	WEIGHT:	BUILD:	HAIR:	EYES:	COMPLEXION:	ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)
TDCJ EMPLOYEE?	EMPLOYEE JOB TITLE:			EMPLOYEE JOB LOCATION					
☐ Yes ☐ No									
TDCJ OFFENDER?	PAROLEE?	SID#		FBI#		ADDITIONAL INFORMATION: (DO NOT USE SS#)			
☐ Yes ☐ No	☐ Yes ☐ No								
SUBJECT #2 NAME: (LAST, First, MI)			ADDRESS:						
RACE:	SEX:	DOB:	HEIGHT:	WEIGHT:	BUILD:	HAIR:	EYES:	COMPLEXION:	ID #: (DO NOT USE SS#) (USE RANK FOR EMPLOYEE)
TDCJ EMPLOYEE?	EMPLOYEE JOB TITLE:			EMPLOYEE JOB LOCATION					
☐ Yes ☐ No									
TDCJ OFFENDER?	PAROLEE?	SID#		FBI#		ADDITIONAL INFORMATION: (DO NOT USE SS#)			
☐ Yes ☐ No	☐ Yes ☐ No								
DRUG RELATED?	TYPE:						AMOUNT:		
☐ Yes ☐ No									
BOOKED?	LOCATION:		BOND:	PROPERTY SEIZED/CONFISCATED?		IF YES, DESCRIBE:			
☐ Yes ☒ No				☐ Yes ☒ No					

SUMMARY: ADDENDUM ATTACHED NO

On July 15, 2004, at 9:30 p.m., Offender Robertson was found unresponsive in his cell at the Darrington Unit with a 108-degree temperature. Robertson was transported by Life Flight to Hospital Galveston for treatment of possible heat stroke. Treatment and life saving measures were unsuccessful. On July 16, 2004, at 3:10 p.m., Robertson was pronounced deceased.

C Eckert — 175 — 4-4-2005
Investigator's Signature — ID# — DATE

Joe Meanth — 108 — APR 0 4 2005
Approving Supervisor's Signature — ID# — DATE

CC-0240 (08/2003) Page 1 of 1

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

CRIMINAL CASE REPORT

OFFENSE	CASE #:
Death in Custody CCP 49.18	04-1679
LOCATION:	DATE OF OFFENSE:
Darrington Unit	July 16, 2004
VICTIM:	DATE OF SUPPLEMENT REPORT:
Robertson, Ricky	April 1, 2005

CASE NARRATIVE:

Offender Ricky Robertson, TDCJ # 1172218, was a thirty-eight year old male serving a three-year sentence out of Harris County for Deadly Conduct. The Texas Department of Criminal Justice-Institutional Division received Offender Robertson on June 23, 2003.

On June 25, 2004, Robertson began receiving Benztropine Mesylate 2 mg (Cogentin) and Symmetrel 100 mg (Amantadine). Robertson was already prescribed Chloropromazine 50 mg (Thorazine), and Lithium Carbonate 300 mg. The orders were for Robertson to be transferred to Jester IV for stabilization and crisis management.

On June 27, 2004, Offender Robertson was transferred from the Lopez Unit to the Jester IV Unit. Robertson was transferred after he complained that he was seeing spiders and things that were not there since his medications were changed.

On June 28, 2004, Robertson was seen for a Mental Health Assessment at the Jester IV Unit. The assessment noted that Robertson was psychotic, disoriented, rambling, paranoid thinking, delusional, and having visual hallucinations. After being evaluated it was suggested that Robertson be seen by the attending psychiatrist to evaluate and adjust his medication.

On June 30, 2004, Nortriptyline 75 mg was added to his medications. On July 7, 2004, after being evaluated, the dosage of Chlorpromazine was increased to 150 mg. On July 9, 2004, Robertson was ready for discharge to his unit of assignment and to continue on his current medication. Robertson was not transferred from the Jester IV Unit until July 15, 2004.

On July 15, 2004, at 6:15 a.m., Offender Robertson was received at the Darrington Unit from the Jester IV Unit. Robertson was in transit status enroute to his unit of assignment, which was the

INVESTIGATING OFFICER(S)
(1) C Eckert
(2) _____
_____
APPROVING SUPERVISOR ID#

IS FURTHER ACTION REQUIRED?
____ YES ✓ NO

STATUS OF CASE – Date_____
____ U – Unfounded
____ P – Cleared by Arrest
____ E – Cleared by Exception
____ I – INACTIVE Investigation Suspended
✓ A – CLD/ADMN Closed Administratively

CC-0260 (08/2003)

Lopez Unit. Robertson was assigned to H Wing, Two Row, Three Cell. Robertson was the only offender assigned to the cell.

Robertson's Health Summary showed that he had the following medical restrictions:

No Temperature Extremes
No Humidity Extremes
No Exposure to Direct Sunlight

There were no special orders provided to security or medical personnel concerning any of the medications taken by Robertson. When Robertson arrived at the Darrington Unit, Robertson voiced no complaints of feeling ill or of being overheated. Robertson, due to being placed in transit status, did not have the opportunity to go to recreation. Robertson received his meals at his cell and was provided his medications at the appropriate times.

The last time Robertson received medication was on June 15, 2004, at 4:46 p.m. At that time Robertson received Lithium Carbonate 300 mg, Chlorpromazine 100mg, Benztropine Mesylate 2 mg, Amantadine 100 mg, Nortriptyline 75 mg, and Chlorpromazine 50 mg.

On July 15, 2004, at 9:15 p.m., Robertson was found by Officer Everest Mbonu sitting on the bottom bed in his cell with his pants around his ankles. Robertson was unresponsive and having difficulty breathing. Medical staff and additional security personnel were summoned. Robertson was moved from the bed and placed on the floor by Officer Michael Knight and Officer Fidel Gallegos. Robertson was assessed by Nurse Vesta Barnes. Nurse Barnes observed Robertson with no shirt on and his pants down. Robertson was sweating like a person would in heat, but not sweating profusely. Robertson's breathing was rhythmic and his mouth was open. Robertson did not respond to verbal or painful stimuli. Robertson's eyes were open in a stare and he did not blink. Nurse Barnes instructed security personnel to move Robertson to the infirmary. Robertson was placed on a backboard and carried downstairs to an awaiting gurney. Robertson was then taken to the medical department for further treatment.

After arriving in the medical department, Nurse Mary Prater was called to assist in the treatment of Robertson. Nurse Prater observed Robertson to have a fixed stare and rhythmic head movements. Robertson's vital signs were taken and Robertson's axillary temperature was noted as being 108 degrees. Robertson's blood pressure was 98/40, his respirations were 32 per minute, and his pulse was 100 per minute. Security officers in the room were told to get ice packs and bags of ice were placed on Robertson's neck, chin, both armpits, groin, under knees, on his abdomen, and his lower back. An intravenous line of normal saline was started and the on-call

C Ichert — 175 — 4-405
Investigator's Signature — ID# — DATE

physician, Doctor Abraham, was called. Correctional Managed Care paramedics were also called and arrived within five minutes. The paramedics began bagging Robertson with an ambu bag and orders were received to transport Robertson to the nearest hospital. All attempts to intubate Robertson were unsuccessful. The paramedics called Life Flight and another saline bag was started after the first one was emptied. When Life Flight arrived the team members took Robertson's rectal temperature, which was now at 103.6. Robertson was bundled in a blanket with ice to his groin area and taken to the helicopter. Life Flight departed on July 15, 2004, at approximately 11:55 p.m.

On July 16, 2004, at approximately 12:24 a.m., Robertson arrived at the University of Texas Medical Branch-Galveston. Robertson was treated in the UTMB Emergency Room. Robertson developed hypotension, which was treated with Dopamine and Epinephrine. A toxicology study indicated a level of tricyclic antidepressants at 600 ng/ml, which is a toxic, but not lethal level. Additional laboratory results revealed acute renal insufficiency, disseminated intravascular coagulopathy, rhabdomyolysis, lactic acidosis, and myocardial damage.

On July 16, 2004, at 4:00 a.m., Robertson was admitted to the Intensive Care Unit for altered mental status, hypotension, and respiratory failure. At 4:20 a.m., Doctor Sunil Movva placed Robertson on the critical list. Robertson's condition continued to deteriorate. At 2:45 p.m., Robertson's family was notified of his status. Robertson's brother, Roy Robertson, was informed of the poor prognosis and agreed with the "Do Not Resuscitate" decision as well as withholding all medical intervention. Robertson was on a ventilator and remained unresponsive. Robertson's blood pressure dropped and an EKG showed a flat line (asystole). On July 16, 2004, at 3:10 p.m., Robertson was pronounced deceased by Doctor William Beary.

On July 16, 2004, at 3:58 p.m., Office of the Inspector General, Investigator Cesar Sanchez, was notified and responded to UTMB. Investigator Sanchez examined the body and took photographs of the decedent. The decedent was then transferred to the UTMB Morgue awaiting an autopsy.

On July 16, 2004, an attempt was made to contact Roy Robertson, Robertson's brother. On July 17, 2004, Lieutenant Stacy Mickens made contact with Roy Robertson and asked if the family would claim Robertson's remains. Mr. Robertson called back on July 19, 2004, and stated that the family would not claim the remains and requested Robertson be buried at the Huntsville Cemetery.

On July 19, 2004, at 10:30 a.m., Doctor Juan Olano, Pathologist, with the University of Texas Medical Branch-Autopsy Division performed the autopsy on Robertson. In the report the Neuropathology Consultation showed that the main cause of death was cardiac arrest secondary

C Ickert 175 4-4-05
Investigator's Signature ID# DATE

to tricyclic antidepressant overdose. The manner of death was listed as natural. This was not, however; the complete and final report. On November 22, 2004, Investigator Sanchez received the final autopsy report. **The final report listed the cause of death as complications of severe hyperthermia and heat stroke with an important factor being a toxic level of tricyclics in serum. The manner of death was accidental.**

I telephoned Doctor Olano, who performed the autopsy on Offender Robertson. Doctor Olano was asked about the conflict in the reporting of the manner of death. Doctor Olano stated that the Neuropathology Consultation listed the clinical history and the causes known to that department. Many of the things listed as contributing factors were caused when Robertson's body shut down from the hyperthermia. The overall autopsy, including toxicology, revealed a broader picture of the cause of death. The cause of death was listed as severe hyperthermia and heat stroke. Doctor Olano stated that this was due to environmental (outside) temperatures, which produced the accidental manner of death. Doctor Olano stated that some anti-depressants and anti-psychotic medications leave the person taking these medications at a high risk of heat stroke. Doctor Olano stated that a normal person with high outside temperatures (100 degrees or higher), who exercises, and has limited or no fluid intake would be susceptible to heat stroke. Those taking anti-depressants and anti-psychotic medications while exercising, with lower temperatures (high 90's), and/or dehydration could have the same effect. Doctor Olano stated that the medications "mess up" heat loss mechanisms in the body. Doctor Olano stated that extreme dehydration causes a person to sweat profusely to bring down the body temperature, and at some point a person will stop sweating. Doctor Olano stated that at this point the body temperature would rise. Doctor Olano stated that there was no evidence to support that Robertson's condition was related to an overdose. Doctor Olano stated that the tricyclic serum level was at 660 ng/ml, which was a toxic, but not lethal level. Doctor Olano stated that the serum level after the time of death was probably lower before death. Doctor Olano stated that medications were not measured post mortem because there was not enough serum to quantitate.

I obtained a copy of the Administrative Directive related to temperature extremes. Most of the directive is related to work assignments, not to actual housing assignments. The directive included a heat and humidity index. I also obtained a temperature history for July 15, 2004. Based on the temperature history for Houston, Texas, the highest temperature for the day was listed at 98.1 with a humidity of 40%. Based on the heat and humidity matrix, the scale listed the average temperature would have been close to 101, with may have created a situation where heat exhaustion was possible.

I obtained copies of the pharmaceutical information and alerts for the medications taken by Robertson. When reviewing the adverse reactions for Chlorpromazine Hydrochloride it stated

C Ichert — 175 — 4-4-05
Investigator's Signature — ID# — DATE

that in the central nervous system there could be extrapyramidal reactions, drowsiness, sedation, seizures, tardive dyskinesia, pseudoparkinsonism, dizziness, or **neuroleptic malignant syndrome**. It also noted an alert to watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, **hyperthermia**, autonomic disturbance), **which was rare but usually fatal**. It noted that this may not be related to length of the drug use or type of neuroleptic, but more than 60% of affected patients are men.

The housing area where Robertson was assigned was cooled by fans only. Robertson was in transit status back to his original unit of assignment and the Darrington Unit was used routinely to house offenders transferring between units. There were no special instructions specifically listed for Robertson concerning an air-conditioned housing location. Doctor Olano stated that the environmental (outside) temperatures, produced the accidental manner of death.

VICTIM(S) STATEMENT:
The victim is deceased.

SUSPECT(S) STATEMENT:
No suspects.

WITNESSES:
Mbonu, Everett, Correctional Officer, Darrington Unit: Mbonu stated that Offender Robertson was an offender in transit status. Mbonu stated that Robertson was brought to H Line during his shift from 1:30 p.m. to 9:30 p.m. Mbonu stated that Robertson was placed in H-2-3 cell and at the time he showed no signs of illness. Mbonu stated that Robertson never complained to him of being ill. Officer Mbonu stated that he provided Robertson with a mattress and sheets, and also provided him with a meal. Officer Mbonu stated that during his security check at 9:15 p.m., Robertson was in a state that he felt required immediate medical attention Officer Mbonu stated that he called for assistance and other officers and medical staff responded. Officer Mbonu stated that Robertson was placed on a stretcher and moved to the infirmary. Officer Mbonu provided a written statement. C. Eckert

King, Clifford, Sergeant, Darrington Unit: Sergeant King told me that on July 15, 2004, at 9:35 p.m., he and other supervisors were called to H-Line. He stated that he went to H-2-3 cell and saw Robertson lying on the bottom bunk with his back against the wall and his feet hanging off the bunk. Sergeant King stated that it looked like Robertson was having a seizure. Sergeant King stated that Robertson was moved from the cell to a gurney and transported to the medical department. Sergeant King stated that the medical staff checked Robertson's medical folder and found no history of seizures, or diabetes, but Robertson was on mental health medication.

C Eckert 175 4-4-05
Investigator's Signature ID# DATE

Sergeant King stated that the medical staff tried ammonia tabs and a needle to test for pain and there was no effect. Sergeant King stated that medical staff took Robertson's temperature and it registered at 108 degrees. Sergeant King stated that medical staff placed ice packs around Robertson to bring his temperature down. Sergeant King noticed that Robertson's pants were around his ankles and a visual rectal exam was completed. Sergeant King stated that an intravenous line (IV) was started and medical staff contacted the on call doctor. The doctor ordered that Robertson be life-flighted to Hospital Galveston. Sergeant King stated that the Southern EMS arrived, took vitals and started another IV. Sergeant King stated that at 11:45 p.m. Robertson was life-lighted to Hospital Galveston. Sergeant King stated that on July 16, 2004, at 12:30 a.m., he went to Robertson's cell and found that there was no other offender assigned to the cell and Robertson had no property or keep on person (KOP) medication in the cell. Sergeant King stated that he noticed what appeared to be vomit on the mattress of the top bunk. Sergeant King stated that photographs were taken of the cell and the cell was secured with red tape to prevent access. Sergeant King provided a written statement.

Haley, Howard, Lieutenant, Darrington Unit: Lieutenant Haley told me that based on the count room information Robertson arrived at the Darrington Unit on July 15, 2004, at 6:15 a.m. and was housed in H-2-3 cell. Lieutenant Haley also stated that Robertson was taken to the pill window at 4:30 p.m. on July 15, 2004, and had no other documentation of any activity involving Robertson until 9:35 p.m. Lieutenant Haley stated that Robertson was in transit status and would not have participated in recreation on July 15, 2004. Lieutenant Haley stated that at 9:35 p.m., he responded to H-Line. Lieutenant Haley stated that he remembered that Robertson was sitting on the bunk leaning back and his breathing was irregular. Lieutenant Haley stated that Sergeant Stephens shook Robertson and got no response. Lieutenant Haley stated that Nurse Prater tried ammonia capsules with no response. Lieutenant Haley stated that Robertson was placed on a backboard, carried to a gurney, and then transported to the infirmary. Lieutenant Haley stated that while in the infirmary, ammonia capsules were again used with no response. Lieutenant Haley stated that Nurse Prater used a needle to check for pain stimuli and at this point he was in and out of the infirmary on several occasions. Lieutenant Haley stated that he was informed that Robertson's vital signs were checked and Robertson's temperature was recorded at 108 degrees. Lieutenant Haley stated that medical staff gathered ice packs and covered Robertson's body with ice. Lieutenant Haley also stated that when Robertson was found his pants were down around his ankles. Lieutenant Haley stated that due to this fact, Nurse Prater examined Robertson's rectal area for signs of a sexual assault and no signs were found. Lieutenant Haley stated that Southern Region EMS arrived and the diagnosis was heat stroke at that point. Lieutenant Haley stated that throughout this time he was busy contacting key personnel with updates. Lieutenant Haley stated that he was notified that Robertson had stopped breathing and was being assisted by medical staff. Lieutenant Haley stated that Life-Flight was ordered and he had security personnel go to the parking lot to secure the landing zone. Lieutenant Haley stated that he left the infirmary and returned when Robertson was being moved to the parking lot. Lieutenant Haley stated that he went to the parking lot along with medical staff. Lieutenant Haley stated that medical staff

C. Eckert 175 4-4-05
Investigator's Signature ID# DATE

Approving Supervisor's Signature ID# DATE

loaded Robertson on the helicopter and the helicopter left. Lieutenant Haley stated that the cell was secured as a crime scene and Robertson had no property in the cell and had no cell partner.

Stephens, Michael, Sergeant, Darrington Unit: Sergeant Stephens stated that at 9:35 p.m. on July 15, 2004, the control picket told him that there was an emergency on H-Line. Sergeant Stephens stated that he went to H-2-3 cell where he observed Offender Robertson lying on the bottom bunk with his feet on the floor. Sergeant Stephens stated that Robertson was unresponsive, his breathing was irregular, and he was slightly shaking. Sergeant Stephens stated that he called for medical staff and a gurney, but Nurse Barnes had already arrived. Sergeant Stephens ordered that the door be opened to the cell and he entered the cell with other officers. Sergeant Stephens stated that he gently shook Robertson to check for responsiveness, but Robertson did not respond. Sergeant Stephens stated that Nurse Barnes then tried to use an ammonia capsule, but Robertson still did not respond. Sergeant Stephens stated that Robertson was the only offender in the cell. Sergeant Stephens stated that he and the officers carried Robertson out of the cell, carried him downstairs, and placed Robertson on a gurney. Sergeant Stephens stated that he and Nurse Barnes took Robertson to the infirmary where he was placed in the emergency room. Sergeant Stephens stated that Lieutenant Haley and Sergeant King then relieved him. Sergeant Stephens provided a written statement.

Knight, Michael, Correctional Officer, Darrington Unit: Officer Knight told me that on July 15, 2004, at 9:35 p.m., he responded to a medical emergency call at H-2-3 cell. Officer Knight stated that when he entered the cell he observed the offender sitting on his bunk at the far end of the bunk, his hands at his side, and his pants down around his ankles, leaning over the desk in the cell. Officer Knight stated that it appeared that the offender was not breathing. Officer Knight stated that he helped place the offender on the floor and he was unresponsive. Officer Knight stated that the nurse tried an ammonia pack and he was still unresponsive. Officer Knight stated that he assisted in placing the offender on a backboard, carrying the offender down the stairs, and placing the offender on a gurney. Officer Knight stated that he and Sergeant Stephens escorted the offender to the infirmary. Officer Knight stated that he returned to his assigned duties. Officer Knight added that the offender was alone in the cell. Officer Knight provided a written statement.

Gallegos, Fidel, Correctional Officer, Darrington Unit: Officer Gallegos stated that he was advised of a medical emergency on H-Line and went to H-2-3 cell. Gallegos stated that he observed Offender Robertson sitting on the bottom bunk with his pants around his ankles leaning toward the desk. Gallegos stated that Offender Robertson was having problems breathing and was unresponsive. Gallegos stated that the cell door was opened and he helped place Robertson on the floor. Gallegos stated that after the nurse assessed Robertson; he assisted in placing Robertson on a backboard. Gallegos stated that Robertson was carried downstairs and placed on a gurney. Gallegos stated that he was then ordered to return to his duty post.

C Ichert 175 4405
Investigator's Signature ID# DATE

Approving Supervisor's Signature ID# DATE

Barnes, Vesta, Nurse, Darrington Unit: Nurse Barnes told me that she responded to H Line. Nurse Barnes stated that security was in the cell and the cell door was open. Nurse Barnes stated that she entered the cell and observed Robertson with no shirt on and his pants down. Barnes stated that it was a hot night and Robertson was sweaty. Barnes described that Robertson was sweating like a person would in heat, but not sweating profusely. Nurse Barnes stated that Robertson was breathing rhythmically with his mouth open. Nurse Barnes stated that Robertson did not respond to verbal or painful stimuli. Nurse Barnes stated that Robertson's eyes were open in a stare and he did not blink. Nurse Barnes stated that Robertson was immediately placed on a stretcher and she did no treatment or further assessment at the cell. Nurse Barnes stated that once Robertson was placed on a stretcher he was taken to the infirmary emergency room. Nurse Barnes stated that she took Robertson's temperature auxiliary and his temperature was 108 degrees. Nurse Barnes stated that they began packing Robertson in ice. Nurse Barnes stated that she was in and out of the room calling the doctor, emergency medical services (EMS), and sending messages. Nurse Barnes stated that Nurse Prater stayed in the room with Robertson and then EMS came to assist. Nurse Barnes stated that she did recall that it was a very hot night, but not unusual for the middle of July, and there were only fans in the cellblock area. Nurse Barnes stated that while at the cell she did not notice anything unusual.

Prater, Mary, Nurse, Darrington Unit: Nurse Prater stated she was in the medical department when she was called to assist Nurse Barnes. Prater stated that when she first saw Robertson, she observed his fixed stare and rhythmic head movements. Prater stated that Robertson's axillary temperature was 108, but would probably be one degree higher, orally. Prater stated that Robertson's blood pressure was 98/40 and his respirations were 32 per minute. Prater stated that Robertson's pulse was 100 per minute. Prater stated that officers in the room were told to get ice packs and bags of ice were placed on Robertson's neck, chin, both armpits, groin, under knees, as well as on his abdomen and lower back. Prater stated that an IV of normal saline was started and someone called the on-call physician. Prater stated that paramedics were also called and arrived within five minutes. Prater stated that the paramedics began bagging Robertson with an ambu bag and orders were received to transport Robertson to the nearest hospital. Prater stated that all attempts to intubate Robertson were unsuccessful. Prater stated that the paramedics called Life Flight and another saline bag was started after the first one was emptied. Prater stated that when Life Flight arrived the team members took Robertson's rectal temperature, which was now at 103.6. Prater stated that Robertson was bundled in a blanket with ice to his groin area and taken to the helicopter.

There were several offenders at the Darrington Unit that were on the same row of housing cells as Robertson. Most of the offenders were in transit status at the time and have since been released from TDCJ. The two offenders that were closest to Robertson's cell on July 15, 2004, were interviewed. Neither one of the two offenders remembered hearing or seeing anything unusual and neither knew who Offender Robertson was. The two offenders that were interviewed were:

C. Eckert 175 4-4-05
Investigator's Signature ID# DATE

Approving Supervisor's Signature ID# DATE

Wallace, Nathan, TDCJ # 1220328, Offender, Dawson State Jail: Offender Wallace was assigned to cell H Wing, Two Row, Two Cell at the Darrington Unit on July 15, 2004.

Peavy, Ricky, TDCJ # 657072, Offender, McConnell Unit: Offender Peavy was assigned to H Wing, Two Row, Five Cell, at the Darrington Unit on July 15, 2004.

EVIDENCE:

1. Ten photographs of Robertson after death.
2. One micro cassette tape of the interview of Nurse Barnes.

The original photographs and the micro cassette tape are being held in the evidence room at the Region B OIG Headquarters.

ATTACHMENTS:

1. Investigative Notes
2. A copy of the Attorney General Custodial Death Report completed by Investigator Sanchez.
3. The Investigator's Report of Custodial Death completed by Investigator Sanchez.
4. Ten photographs of Robertson preceding his death. The photographs were taken by Investigator Sanchez.
5. A copy of the TDCJ Autopsy Order.
6. A copy of the Hospital Galveston death notification forms.
7. A copy of Robertson's travel card.
8. Copies of the teletype messages sent concerning Robertson's condition and death, incident number I-07458-07-04.
9. A copy of Robertson's TDCJ/UTMB Medical records dated from April 5, 2004 to July 15, 2004.
10. A copy of Robertson UTMB medical records dated July 15, 2004 to July 16, 2004.
11. A copy of Robertson's entire lab results from July 16, 2004.
12. A copy of the medical transfer order from the Darrington Unit to UTMB on July 15, 2004.

C Ichert — 175 — 4-4-05
Investigator's Signature — ID# — DATE

Approving Supervisor's Signature — ID# — DATE

13. A copy of telex information containing Robertson's unit classification review, medical profile inquiry, medical information history inquiry and health summary classification.

14. A copy of the weather history from July 15, 2004.

15. A copy of the guidelines for health summary classification for offenders.

16. A copy of Administrative Directive 10.64, titled Temperature Extremes in the TDCJ Work Place.

17. A copy of Robertson's medication list from June 27, 2004, and July 7, 2004.

18. A copy of Robertson's medication compliance from June 1, 2004, to July 15, 2004.

19. A copy of the pharmaceutical information on the medications prescribed to Robertson.

20. A copy of the Darrington Unit's administrative review concerning the death of Offender Robertson.

21. A copy of the employee roster for July 15, 2005, for the second shift.

22. The written statement of Officer Everest Mbonu dated January 12, 2005.

23. The written statement of Sergeant Clifford King dated January 12, 2005.

24. The written statement of Lieutenant Harold Haley dated January 12, 2005.

25. The written statement of Sergeant Michael Stephens dated January 12, 2005.

26. The written statement of Officer Michael Knight dated January 12, 2005.

27. The written statement of Officer Fidel Gallegos dated January 13, 2005.

28. The written statement of Nurse Mary Prater dated January 13, 2005.

29. The written statement of Safety Officer Mike Dattalo dated January 12, 2005, and a copy of the temperature reading he took on the morning of July 16, 2004.

30. A copy of the offender roster for H Wing at the Darrington Unit dated July 14, 2004.

C Ochart 175 4-4-05
Investigator's Signature ID# DATE

Approving Supervisor's Signature ID# DATE

CC-0260 (02-2003) Page 10 of 11

31. The supplement report of the interview of Offender Nathan Wallace dated March 14, 2005.

32. The supplement report of the interview of Offender Ricky Peavy dated March 14, 2005.

33. The supplement report of the interview of Nurse Vesta Barnes dated March 29, 2005.

34. A copy of the chain of evidence card for the tape-recorded interview of Nurse Barnes.

35. A copy of the final autopsy report.

36. Copies of Robertson's body taken by UTMB Autopsy Division.

37. A supplement report of the interview with Doctor Olano dated January 11, 2005.

CSE

C Eckert 175 4-4-05
Investigator's Signature ID# DATE

Approving Supervisor's Signature ID# DATE

CC-0260 (02-2003) Page 11 of 11

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

INVESTIGATIVE NOTES

TYPE OF INVESTIGATION:	CASE #:
Criminal Case Death in Custody	04-1679TDCJ

07-15-2004, at approximately 10:30 p.m., I received a call from Warden Weston at the Darrington Unit. He explained that at approximately 9:35 p.m., Offender Ricky Robertson was found in his cell H-2-03 at the Darrington Unit unresponsive. Offender was moved to the infirmary where it was discovered that his blood pressure was low and his temperature was 108* degrees. I requested that his cell be photographed by security and then checked for drugs or any other items that might be useful in his diagnosis and/or for the investigation, incase the offender died. I was notified by telephone that a search of the cell by the supervisor disclosed no suicide note, drugs, etc. The cell was again secured after this search.

07-16-2004, 8:30 a.m., I checked with Warden Weston. The offender was at HG. Since no other evidence could be found and no foul play was suspected, I released the cell to security.

07-16-2004, 3:58 p.m., I received a call from Lieutenant Mickens in Hospital/Galveston that Offender Ricky Robertson died at the facility at 3:10 p.m. I contacted Mark Bowers and obtained authorization to responded and work over time. I responded to Hospital/Galveston. I completed the Custodial Death report, the Investigator's Report of Custodial Death and took pictures of the body. The Medical Examiner's office was contacted and an autopsy was ordered. The provisional cause of death was Sepsis/overdose—Neuroleptic Malignant Syndrome. Likely manner of death is accidental since there is no evidence of foul play.

07-19-2004, I received E-mail from Lt. Mickens where she reported that the brother of offender Robertson, Roy Robertson, would not give an answer whether he would accept the body.

11-22-2004, I received case from Investigator Poole. Pictures of body misplaced. I will request pictures of body prior to autopsy from ME's office. I called Banos in reference to autopsy report; answering machine was on. I contacted Pam and requested the autopsy report. Pam faxed the autopsy report. I read the report.

The report disclosed the following:

INVESTIGATING OFFICER

(1) Davey 139
ID# DATE

AC-00045 (08/2003) PAGE 1

10

The main cause of death is cardiac arrest secondary to tricyclic antidepressant overdose. The manner of death is natural.

I discussed the finding with Lt. Bowers. He explained that the one thing to look for is what the normal dosage for the medications were and factor any precipitating factors, such as drug abuse and/or organ failure into the equation. What this means, as he explained, is that the dosage might have been the proper dosage for the person's weight and age. However, based on the extenuating circumstances, such as a history of drug abuse and/or organ failure—kidney, liver, etc.—could have altered the percentage of the medication in the body, causing the body to overdose without the physician knowing it was occurring.

In this case, Offender Robertson was taking the following medications:

Nortriptyline 75mg
Lithium Carbonate 300mg
Chlorpromazine 100mg
Benztropine Mes 2mg
Amantadine 100mg
Chlorpromazine 50mg

All of the medications on record were within normal prescription ranges for the age and weight of the patient according to PDR-Edition 45, 1991.

The clinical summary of the autopsy report disclosed that the laboratory results revealed the following: (1) acute renal insufficiency (2) disseminated intravascular coagulopathy (3) rhabdomyolysis (4) lactic acidosis (5) myocardial damage.

In the final report of the autopsy, page #9 disclosed that Offender Ricky Robertson "...died of complications of severe hyperthermia and heat stroke," and that "an important contributing factor was a toxic level of tricylics in serum." **Dr. Juan P. Olano ruled the manner of death as accidental.** Cesar Sanchez

I spoke with Dr. Juan P. Olano on the telephone in reference to the initial findings that were reported as to the cause of death. He advised that the report that I was reading was actually the neuropathology consultation report. He reported that when they wrote the initial report the main cause of death was cardiac arrest secondary to tricyclic antidepressant overdose and that the manner of death was natural. He advised that this report was transferred as the initial report to

INVESTIGATING OFFICER

(1) _____ 139 _____
ID# DATE

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679TDCJ

the neuropathology. He reported that he did not have control of over the report that the neuropathologist completed. He also reported that **upon reviewing the laboratory results, he ruled the cause of death to be accidental and his final report supported this.** He faxed the final report that supported the manner of death as being accidental. I requested pictures of the body and the pictures were E-mails to OIG. Case completed. Cesar Sanchez

INVESTIGATING OFFICER

(1) [redacted] 139

ID# DATE

1-2

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

INVESTIGATIVE NOTES

TYPE OF INVESTIGATION:	CASE #:
Criminal Case	04-1679TDCJ

11-22-2004, I received case. Summary: I opened case on 07-19-2004. A review of my planer disclosed that I responded to HG and completed the paperwork. No record of pictures. However, under the circumstances it would be procedural to take photographs of the body. I searched for evidence release form for the pictures, but was unable to come up with one. I contacted Investigator Autrey and asked him to research the evidence log for the pictures. I contacted Banos; answering machine was on. I contacted Pam and requested the autopsy report. Pam faxed the autopsy report. I read the report.

The report disclosed the following:

The main cause of death is cardiac arrest secondary to tricyclic antidepressant overdose. The manner of death is natural.

Question: How can this be?

I discussed the finding with Lt. Bowers. He explained that the one thing to look for is what the normal dosage for the medications were and factor any precipitating factors, such as drug abuse and/or organ failure into the equation. What this means, as he explained, is that the dosage might have been the proper dosage for the person's weight and age. However, based on the extenuating circumstances, such as a history of drug abuse and/or organ failure—kidney, liver, etc.—could have altered the percentage of the medication in the body, causing the body to overdose without the physician knowing it was occurring.

In this case, Offender Robertson was taking the following medications:

Nortriptyline 75mg
Lithium Carbonate 300mg
Chlorpromazine 100mg
Benztropine Mes 2mg
Amantadine 100mg
Chlorpromazine 50mg

INVESTIGATING OFFICER

(1) [signature] 139 (ID#) 12-13-04 (DATE)

AC-00045 (08/2003) PAGE 1

13

TBCJ-OIG-INVESTIGATIONS DIVISION	
INVESTIGATIVE NOTES	CASE #: 04-1679TDCJ

All of the medications on record were within normal prescription ranges for the age and weight of the patient according to PDR-Edition 45, 1991.

The clinical summary of the autopsy report disclosed that the laboratory results revealed the following: (1) acute renal insufficiency (2) disseminated intravascular coagulopathy (3) rhabdomyolysis (4) lactic acidosis (5) myocardial damage.

In the final report of the autopsy, page #9, disclosed that Offender Ricky Robertson "...died of complications of severe hyperthermia and heat stroke," and that "an important contributing factor was a toxic level of tricylics in serum." Dr. Juan P. Olano ruled the manner of death as accidental. Cesar Sanchez

I spoke with Dr. Juan P. Olano on the telephone in reference to the initial findings that were reported as to the cause of death. He advised that the report that I was reading was actually the neuropathology consultation report. He reported that when they wrote the initial report the main cause of death was cardiac arrest secondary to tricyclic antidepressant overdose and that the manner of death was natural. He advised that this report was transferred as the initial report to the neuropathology. He reported that he did not have control of over the report that the neuropathologist completed. He also reported that upon reviewing the laboratory results, he ruled the cause of death to be accidental and his final report supported this. He faxed the final report that supported the manner of death as being accidental.

INVESTIGATING OFFICER

(1) [signature] 139 12-13-04

ID# DATE

1.4

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIONS DEPARTMENT

INVESTIGATIVE NOTES

TYPE OF INVESTIGATION:	CASE #:
Criminal Case Death in Custody	04-1679

01-11-2005 I was called to Captain Nesmith's office. I was assigned this case to reinvestigate and clarify several points concerning the death of Offender Ricky Robertson, TDCJ # 1172218. Offender Robertson was assigned to the Darrington Unit on July 15, 2004, when he was found unresponsive in his cell. Robertson was found to have a temperature of 108, and was life-flighted to Hospital Galveston. Robertson died the next day. The cause of death on the final autopsy report was listed as complications of severe hyperthermia and heat stroke with an important contributing factor was a toxic level of tricyclics in serum. The manner of death was ruled as accidental. The case was reassigned to me to answer questions not included in the original case report. C. Eckert

01-11-2005 I made a list of all the employees that needed to be interviewed. Most would be working the next several days. Both nurses working at the time of the incident are still assigned to the Darrington Unit, but one is out on medical leave. C. Eckert

01-11-2005 I telephoned Doctor Juan Olano, Pathologist, with the University of Texas Medical Branch-Autopsy Division. Doctor Olano performed the autopsy on Offender Robertson. Doctor Olano was asked about the conflict in the reporting of the manner of death. Doctor Olano stated that Neuropathology Consultation listed the clinical history and the causes known to that department. Many of the things listed as contributing factors were caused when his body shut down from the hyperthermia. The overall autopsy, including toxicology, revealed a broader picture of the cause of death. The cause of death was listed as severe hyperthermia and heat stroke. Doctor Olano stated that this was due to environmental (outside) temperatures, which produced the accidental manner of death. Doctor Olano stated that some anti-depressant and anti-psychotic medications leave the person taking these medications at a high risk of heat stroke. Doctor Olano stated that a normal person with high outside temperatures (100 degrees or higher), exercise, and limited or no fluid intake would be susceptible to heat stroke. Those taking these medications while exercising, lower temperatures (high 90's), and/or dehydration could have the same effect. Doctor Olano stated that the medications "mess up" heat loss mechanisms in the body.

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005
ID# DATE

AC-00045 (08/2003) PAGE 1

15

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

Doctor Olano stated that extreme dehydration causes a person to sweat profusely to bring down the body temperature, and at some point a person will stop sweating. Doctor Olano stated that at this point the body temperature would rise. Doctor Olano stated that there was no evidence to support an overdose. Doctor Olano stated that the tricyclic serum level was at 660 ng/ml, which was a toxic, but not lethal level. Doctor Olano stated that the serum level at the time of death was probably lower before death. Doctor Olano stated that medications were not measured post mortem because there was not enough serum to quantitative. Doctor Olano stated that if he could be of any further assistance, to call or page him. C. Eckert

01-11-2005 I contacted the Darrington Unit and requested a completed copy of the unit administrative incident review report. C. Eckert

01-11-2005 I contacted TDCJ/UTMB Decedent Affairs and made contact with Shantel Humphrey. I requested medical records on Robertson from the last three months prior to his death to include any additional records during that time from Hospital Galveston and the Jester IV Unit. I also requested medication information for the same amount of time. I requested that the clinic notes from July 15, 2004, be faxed to me. Ms. Humphrey stated that she would fax the needed information and send the rest by mail. C. Eckert

01-11-2005 I contacted Lucy Limones with UTMB Medical Records. I left a message with Ms. Limones to contact me because I needed the medical records from the day that Robertson was under care at Hospital Galveston preceding his death.

01-11-2005 I telephoned Nurse Prater who was one of the nurses on duty on July 15, 2004. I informed Nurse Prater that as soon as I received the clinic notes from that day I would need her to provide a written statement. Nurse Prater stated that she did remember what occurred on that day and would provide any needed information. Nurse Prater stated that she worked until 6:00 p.m. today and would come to work at 6:00 p.m. tomorrow. C. Eckert

01-11-2005 I received faxed documentation from Ms. Humphrey. The requested clinic notes did not fax to the machine. I contacted Ms. Humphrey who was in a meeting. By 5:00 p.m., I had not heard from Ms. Humphrey or Ms. Limones. C. Eckert

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

16

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

01-12-2005 I telephoned Ms. Humphrey. She stated that the information was sent and may have not gone through. She told me she would send it again. Within minutes I received the requested clinic notes. C. Eckert

01-12-2005 I went to the Darrington Unit. Upon entering the unit I stopped at the warden's office and picked up the copies I requested. I read the documentation and discovered that Robertson was assigned to the Darrington Unit on the morning of July 15, 2004. I also read that Robertson did go to the pill window to take his medication at 4:30 p.m., on July15, 2004. Awaiting medical documentation to support this fact. C. Eckert

01-12-2005 I interview Sergeant Clifford King at the Darrington Unit. Sergeant King told me that on July 15, 2004, at 9:35 p.m., he and other supervisors were called to H-Line. He stated that he went to H-2-3 cell and saw Robertson lying on the bottom bunk with his back against the wall and his feet hanging off the bunk. Sergeant King stated that it looked like Robertson was having a seizure. Sergeant King stated that Robertson was moved from the cell to a gurney and transported to the medical department. Sergeant King stated that the medical staff checked Robertson's medical folder and found no history of seizures, or diabetes, but Robertson was on mental health medication. Sergeant King stated that the medical staff tried ammonia tabs and a needle to test for pain and there was no effect. Sergeant King stated that medical staff took Robertson's temperature and it registered at 108 degrees. Sergeant King stated that medical staff placed ice packs around Robertson to bring his temperature down. Sergeant King noticed that Robertson's pants were around his ankles and a visual rectal exam was completed. Sergeant King stated that an intravenous line (IV) was started and medical staff contacted the on call doctor. The doctor ordered that Robertson be life-flighted to Hospital Galveston. Sergeant King stated that the Southern EMS arrived, took vitals and started another IV. Sergeant King stated that at 11:45 p.m. Robertson was life-lighted to Hospital Galveston. Sergeant King stated that on July 16, 2004, at 12:30 p.m., he went to Robertson's cell and found that there was no other offender assigned to the cell and Robertson had no property or keep on person (KOP) medication in the cell. Sergeant King stated that he noticed what appeared to me vomit on the mattress of the top bunk. Sergeant King stated that photographs were taken of the cell and the cell was secured with red tape to prevent access. Sergeant King provided a written statement. C. Eckert

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

1.7

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

01-12-2005 I interviewed Mike Dattalo, who is the Darrington Unit Safety Officer. Mr. Dattalo told me that he was called and told to respond to the Darrington Unit to take temperature readings. Mr. Dattalo stated that he took the temperature readings on July 16, 2004, at 2:00 a.m. Mr. Dattalo stated that he took reading from the beginning, middle, and the end of each row on H-Line. Mr. Dattalo reported that the temperature on H-2 row in front of # 3 cell was 86 degrees and the humidity was 95%. The rest of the temperatures for H Line are listed in his written statement that he provided. I asked Mr. Dattalo if there were any records kept on temperatures and humidity throughout the year. Mr. Dattalo told me to contact Mike Southard tomorrow because he thought Mr. Southard had a program on his computer containing this information. C. Eckert

01-12-2005 I interviewed Lieutenant Harold Haley. Lieutenant Haley told me that based on the count room information Robertson arrived at the Darrington Unit on July 15, 2004, at 6:15 a.m. and was housed in H-2-3 cell. Lieutenant Haley also stated that Robertson was taken to the pill window at 4:30 p.m. on July 15, 2004, and had no other documentation of any activity involving Robertson until 9:35 p.m. Lieutenant Haley stated that Robertson was in transit status and would not have participated in recreation on July 15, 2004. Lieutenant Haley stated that he at 9:35 p.m., he s responded to H-Line. Lieutenant Haley stated that he remember that Robertson was sitting on the bunk leaning back and his breathing was irregular. Lieutenant Haley stated that Sergeant Stephens shook Robertson and got no response. Lieutenant Haley stated that Nurse Prater tried ammonia capsules with no response. Lieutenant Haley stated that Robertson was placed on a backboard, carried to a gurney, and then transported to the infirmary. Lieutenant Haley stated that while in the infirmary, ammonia capsules were again used with no response. Lieutenant Haley stated that Nurse Prater used a needle to check for pain stimuli and at this point he was in and out of the infirmary on several occasions. Lieutenant Haley stated that he was informed that Robertson's vital signs were checked and Robertson's temperature was recorded at 108 degrees. Lieutenant Haley stated that medical staff gathered ice packs and covered Robertson's body with ice. Lieutenant Haley also stated that when Robertson was found his pants were down around his ankles. Lieutenant Haley stated that due to this fact, Nurse Prater examined Robertson's rectal area for signs of a sexual assault and no signs were found. Lieutenant Haley stated that Southern Region EMS arrived and the diagnosis heat stroke at that point. Lieutenant Haley stated that throughout this time he was busy contacting key personnel with updates. Lieutenant Haley stated

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

that about this time he was notified that Robertson had stopped breathing and was being assisted by medical staff. Lieutenant Haley stated that Life-Flight was ordered and he had security personnel go to the parking lot to secure the landing zone. Lieutenant Haley stated that he left the infirmary and returned when Robertson was being moved to the parking lot. Lieutenant Haley stated that he went to the parking lot along with medical staff. Lieutenant Haley stated that medical staff loaded Robertson on the helicopter and the helicopter left. Lieutenant Haley stated that the cell was secured as a crime scene and Robertson had no property in the cell and had no cell partner. While talking to Lieutenant Haley, he informed me that one thing that was not included in any report was the officer who rode on the helicopter. Lieutenant Haley stated the name of the officer was Cheryl Davis and she was assigned to third shift. Lieutenant Haley provided a written statement. C. Eckert

01-12-2005 I interviewed Sergeant Michael Stephens. Sergeant Stephens stated that at 9:35 p.m. on July 15, 2004, the control picket told him that there was an emergency on H-Line. Sergeant Stephens stated that he went to H-2-3 cell where he observed Offender Robertson lying on the bottom bunk with his feet on the floor. Sergeant Stephens stated that Robertson was unresponsive, his breathing was irregular, and he was slightly shaking. Sergeant Stephens stated that he called for medical staff and a gurney, but Nurse Barnes had already arrived. Sergeant Stephens ordered that the door be opened to the cell and he entered the cell with other officers. Sergeant Stephens stated that he gently shook Robertson to check for responsiveness, but Robertson did not respond. Sergeant Stephens stated that Nurse Barnes then tried to use an ammonia capsule, but Robertson still did not respond. Sergeant Stephens stated that Robertson was the only offender in the cell. Sergeant Stephens stated that he and the officers carried Robertson out of the cell, carried him downstairs, and placed Robertson on a gurney. Sergeant Stephens stated that he and Nurse Barnes took Robertson to the infirmary where he was placed in the emergency room. Sergeant Stephens stated that Lieutenant Haley and Sergeant King then relieved him. Sergeant Stephens provided a written statement. C. Eckert

01-12-2005 I interviewed Officer Michael Knight. Officer Knight told me that on July 15, 2004, at 9:35 p.m., he responded to a medical emergency call at H-2-3 cell. Officer Knight stated that when he entered the cell he observed the offender sitting on his bunk at the far end of the bunk, his hands at his side, and his pants

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

down around his ankles, leaning over the desk in the cell. Officer Knight stated that it appeared that the offender was not breathing. Officer Knight stated that he helped place the offender on the floor and he was unresponsive. Officer Knight stated that the nurse tried an ammonia pack and he was still unresponsive. Officer Knight stated that he assisted in placing the offender on a backboard, carrying the offender down the stairs, and placing the offender on a gurney. Officer Knight stated that he and Sergeant Stephens escorted the offender to the infirmary. Officer Knight stated that he returned to his assigned duties. Officer Knight added that the offender was alone in the cell. Officer Knight provided a written statement. C. Eckert

01-12-2005 I checked with inmate records at the Darrington Unit. I attempted to ascertain the H-Line housing roster for July 15, 2004. I was informed that if the roster was kept, it was already moved to storage. An attempt to locate the roster will be made. C. Eckert

01-12-2005 I interviewed Officer Everest Mbonu. Mbonu stated that Offender Robertson was an offender in transit status. Mbonu stated that Robertson was brought to H Line during his shift. Mbonu stated that Robertson was placed in H-2-3 cell and at the time he showed no signs of illness. Mbonu stated that Robertson never complained to him of being ill. Officer Mbonu stated that he provided Robertson with a mattress and sheets, and also provided him with a meal. Officer Mbonu stated that during his security check at 9:15 p.m., Robertson was in a state that he felt required immediate medical attention Officer Mbonu stated that he called for assistance and other officers and medical staff responded. Officer Mbonu stated that Robertson was placed on a stretcher and moved to the infirmary. Officer Mbonu provided a written statement. C. Eckert

01-13-2005 I received the requested medical records from TDCJ/UTMB Decedent Affairs. The records revealed that Offender Robertson was transferred from the Lopez Unit to the Jester IV Unit on June 27, 2004, after he complained that he was seeing spiders and things that were not there, since his medications were changed. On June 25, 2004, Robertson began receiving Benztropine Mesylate 2 mg (Cogentin) and Symmetrel 100 mg (Amantadine). Robertson was already prescribed Chloropromazine 50 mg (Thorazine), and Lithium Carbonate 300 mg. The orders were for Robertson to be transferred to Jester IV for stabilization/crisis management. On June 28, 2004, Robertson was seen for a Mental Health

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

110

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

Assessment. The assessment noted that Robertson was psychotic, disoriented, rambling, paranoid thinking, delusional, with visual hallucinations. After being evaluated it was suggested that Robertson be seen by the attending psychiatrist to evaluate and adjust medication. On June 30, 2004, Nortriptyline was added to his medications. On July 7, 2004, after being evaluated the dosage of Chlorpromazine was increased from to 150 mg a day. On July 9, 2004, Robertson was ready for discharge to his unit of assignment and to continue on current medication. Robertson was not transferred from the Jester IV until July 15, 2004. C. Eckert

01-13-2005 I interviewed Officer Fidel Gallegos at the Ramsey III Training Academy. Officer Gallegos was attending in-service training. Officer Gallegos stated that he was advised of a medical emergency on H-Line and went to H-2-3 cell. Gallegos stated that he observed Offender Robertson sitting on the bottom bunk with his pants around his ankles leaning toward the desk. Gallegos stated that Offender Robertson was having problems breathing and was unresponsive. Gallegos stated that the cell door was opened and he helped place Robertson on the floor. Gallegos stated that after the nurse assessed Robertson; he assisted in placing Robertson on a backboard. Gallegos stated that Robertson was carried downstairs and placed on a gurney. Gallegos stated that he was then ordered to return to his duty post. Officer Gallegos provided a written statement. C. Eckert

01-13-2005 I interviewed Nurse Mary Prater. Nurse Prater stated she was in the medical department when she was called to assist Nurse Barnes. Prater stated that when she first saw Robertson, she observed his fixed stare and rhythmic head movements. Prater stated that Robertson's axillary temperature was 108, but would probably be one degree higher, orally. Prater stated that Robertson's blood pressure was 98/40 and his respirations were 32 per minute. Prater stated that Robertson's pulse was 100 per minute. Prater stated that officers in the room were told to get ice packs and bags of ice were placed on Robertson's neck, chin, both armpits, groin, under knees, and well as on his abdomen and lower back. Prater stated that an IV of normal saline was started and someone called the on-call physician. Prater stated that paramedics were also called and arrived within five minutes. Prater stated that the paramedics began bagging Robertson with an ambu bag and orders were received to transport Robertson to the nearest hospital. Prater stated that all attempts to intubate Robertson were unsuccessful. Prater stated that the paramedics called Life Flight and another saline bag was started after the first one was emptied. Prater stated that when Life Flight arrived the team members

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

TBCJ-OIG-INVESTIGATIONS DIVISION	Death In Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

took Robertson's rectal temperature, which was now at 103.6. Prater stated that Robertson was bundled in a blanket with ice to his groin area and taken to the helicopter. Nurse Prater provided a written statement. C. Eckert

01-13-2005 I obtained a copy of a medication reference handbook for nurses from Nurse Prater. I copied information on all the medications taken by Offender Robertson. One of the medications taken by Robertson, Chlorpromazine Hydrochloride showed an alert which, which stated, "Watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, hyperthermia, autonomic disturbance), which is rare but usually fatal. It may not be related to length of drug use or type of neuroleptic; more than 60% of affected patients are men." C. Eckert

01-14-2005 I contacted Ms. Humphrey again and requested blood work completed at Hospital Galveston and a detailed list of when and how much medication Robertson received from June 25, 2004, until the date of his death. Ms. Humphrey faxed the blood work, but stated that the medication information would take a little longer. C. Eckert

01-14-2005 Lucy Limones with UTMB left a message for me to contact her. C. Eckert

01-14-2005 I contacted Lucy Limones. I told her that I needed medical records expedited to me. Ms. Limones told me to send the request to Julia Solis in Medical Records Release and she would contact her and tell her to expedite. I faxed the request to Ms. Solis. C. Eckert

01-24-2005 I received the medical records from UTMB Galveston showing the records for Robertson's last day before death. C. Eckert

01-28-2005 Captain Nesmith contacted me and told me that Mr. Rhoten requested that I check on the transportation of Robertson and if any orders were provided about the medication sensitivity. C. Eckert, # 175

01-28-2005 I contacted Mr. Rogers, Nurse Manager, at the Jester IV Unit. Mr. Rogers stated that there was no separate blue chart for Roberson, because he was not admitted. Mr. Rogers stated that he was only there for evaluation. Mr. Rogers stated that there was probably no separate order for Robertson and that there were a large

INVESTIGATING OFFICER

(1) C Eckert 175 01-2005

ID# DATE

1.12

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

number of offenders on the medications taken by Roberson. Mr. Rogers stated that because Robertson was not admitted, the medical staff may have not seen him every day and that is why there were days with no entries. C. Eckert, # 175

01-28-2005 I contacted Classification Chief Dickerson at the Ramsey II Unit and asked him for a copy of guidelines for completing health summary for classification. Robertson's Health Summary list no extreme temperatures or humidity. These classifications are mostly for work assignments. I also contacted Zack Thomas, Safety Officer, Ramsey II Unit, and requested a copy of the Administrative Directive related to temperature extremes. Most of that is related to work assignments, but did provide a heat and humidity index. Based on the temperature history for Houston, Texas, the highest temperature for the day was listed at 98.1 with a humidity of 40%. Based on the matrix, the scale listed the average temperature would have been close to 101, with heat exhaustion possible. This was at 4:53 p.m. C. Eckert, # 175

01-31-2005 I contacted Shantel Humphrey to check on the status of the medicine records and if there were any nurses' notes that were not in the records concerning the transportation of Robertson. Ms. Humphrey stated that the records were sent to UTMB for peer review, but she recalled there were no other records than what was sent. Ms. Humphrey stated that she would check the computer screen to see if any other notes were documented there. Ms. Humphrey stated that she has not heard anything about the medicine dispense records and would look into it and get back with me. C. Eckert, # 175

2-10-2005 I received the medication compliance report requested on Offender Robertson. The discharge summary was still not available. C. Eckert, # 175

3-14-2005 I still have not received the discharge summary from Ms. Humphrey. C. Eckert, # 175

3-14-2005 I contacted Investigator Belinowski for an RFA. I requested to speak with Offender Nathan Wallace, TDCJ# 1220328, who was assigned to the Dawson State Jail. Investigator Belinowski checked with security and found that Wallace suffered from mental health issues and security had to fight him anytime they attempted to escort him from his cell. Investigator Belinowski stated that he would go to Wallace's cell and ask him about the incident. Investigator

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

1,12

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

Belinowski contacted me after he talked to Wallace and told me that Wallace did not know Robertson or remember hearing anyone complain of illness or injury. C. Eckert, # 175

3-14-2005 I contacted Investigator Shelia Thomas at the McConnell Unit and requested to speak with Offender Ricky Peavy, TDCJ # 657072. I spoke to Offender Peavy who told me that he did not remember anyone having any medical problems or needing any medical assistance. Peavy stated that he was transferred to Darrington occasionally on his way to and from Hospital Galveston. Peavy stated that the only incident that he recalled was one time when a black female officer worked and he heard an unknown offender ask for his medication. Peavy stated that the incident happened a long time ago and he does not remember anything unusual happening. C. Eckert, # 175

3-21-2005 I attempted to make contact with Nurse Barnes who is out on medical leave. I left a message on her answering machine at her residence. I included my name and return telephone number. C. Eckert, # 175

3-25-2005 I attempted to contact Nurse Barnes. I left another message on her answering machine. C. Eckert, # 175

3-28-2005 Nurse Barnes called the office, but I was not available. C. Eckert, # 175

3-29-2005 I contacted Nurse Barnes and advised her of the reason that I needed to speak with her. Nurse Barnes agreed to be audio recorded. Nurse Barnes told me that she responded to H Line. Nurse Barnes stated that security was in the cell and the cell door was open. Nurse Barnes stated that she entered the cell and observed Robertson with no shirt on and his pants down. Barnes stated that it was a hot night and Robertson was sweaty. Barnes described that Robertson was sweating like a person would in heat, but not sweating profusely. Nurse Barnes stated that Robertson was breathing rhythmically with his mouth open. Nurse Barnes stated that Robertson did not respond to verbal or painful stimuli. Nurse Barnes stated that Robertson eyes were open in a stare and he did not blink. Nurse Barnes stated that Robertson was immediately placed on a stretcher and did no treatment or further assessment at the cell. Nurse Barnes stated that once Robertson was placed on a stretcher he was taken to the infirmary emergency room. Nurse Barnes stated that she took Robertson's temperature auxiliary and his temperature was 108

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

1.14

TBCJ-OIG-INVESTIGATIONS DIVISION	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

degrees. Nurse Barnes stated that they began packing Robertson in ice. Nurse Barnes stated that she was in and out of the room calling the doctor, emergency medical services (EMS), and sending messages. Nurse Barnes stated that Nurse Prater stayed in the room with Robertson and then EMS came to assist. Nurse Barnes stated that she did recall that it was a very hot night, but not unusual for the middle of July, and there were only fans in the cellblock area. Nurse Barnes stated that while at the cell she did not notice anything unusual. C. Eckert, # 175

4-1-2005 The case was typed and forwarded for review. C. Eckert, # 175

INVESTIGATING OFFICER

(1) C Eckert 175 4-1-2005

ID# DATE

115

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL

SUPPLEMENT CRIMINAL CASE REPORT

OFFENSE	CASE #:
Death in Custody CCP 49.18	04-1679
LOCATION:	DATE OF OFFENSE:
Hospital Galveston	July 16, 2004
VICTIM:	DATE OF SUPPLEMENT REPORT:
Robertson, Ricky TDCJ # 1172218	June 1, 2005

On April 25, 2005, I received this case to gather additional information concerning the medications administered to Offender Robertson and whether the dosage or mixture of medications contributed to Robertson's death. I also gathered additional information concerning whether the medications in conjunction with the temperature extremes may have contributed to Robertson's death.

On April 25, 2005, I contacted the Texas Department of Criminal Justice-Health Services Division and asked to speak with Director Lannette Linthicum, M.D.,FACP. Doctor Linthicum returned my call on April 26, 2005, and informed me that she was familiar with the death of Offender Ricky Robertson and that two committees had reviewed the case. Doctor Linthicum stated that the peer review and any findings or recommendations could not be released. Doctor Linthicum stated that the proceedings and findings were protected by statute from disclosure. I asked Doctor Linthicum if a letter could be written explaining what could be disclosed and any other information that could be useful to the investigation. Doctor Linthicum stated that she would provide a letter detailing what could be disclosed. I also asked Doctor Linthicum if it could be determined if the medication taken by Robertson was administered properly and in the correct dosage. Doctor Linthicum stated that she would have Stephanie Zepeda, Assistant Director of Pharmacy complete a clinical pharmacology consult on the medication taken by Robertson.

On May 3, 2005, I received a copy of the letter completed by Doctor Linthicum. In the letter it stated that two Health Care Committees of the Correctional Managed Health Care Program had reviewed the death of Ricky Robertson. The committees were the Joint Morbidity and Mortality Committee and the Physician Peer Review Committee. Doctor Linthicum stated that she was unable to share specific actions taken by the committees because the proceedings and findings are protected by statute from disclosure. Doctor Linthicum stated that corrective action was recommended with respect to clinical process and care issues. Doctor Linthicum stated that she expressed her concern about some of the clinical issues in this case and expressed her desire that the corrective action outline by the Peer Review process be "expeditiously completed."

INVESTIGATING OFFICER(S)	ID#	DATE	IS FURTHER INVESTIGATIVE ACTION REQUIRED?
(1) C Ichert	175	6-2-05	
(2)	ID#	DATE	___ YES ✓ NO
APPROVING SUPERVISOR J W Nesmith	108	6/4/05	
	ID#	DATE	

CC-0255 (02/2005)

Doctor Linthicum also stated that TDCJ does not have any tempered air or air conditioned units/facilities and there are only 2,000 psychiatric beds, which are air-conditioned, that serve the entire TDCJ system. Doctor Linthicum further stated that the majority of the mental health offenders are outpatient and do not meet clinical criteria for inpatient care. Doctor Linthicum stated that there are approximately **17,000 offenders** on outpatient mental health caseloads and large portions of them receive psychotropic medication. Doctor Linthicum stated that there has been a marked reduction of heat related illnesses in offenders and staff, and short of building new facilities with tempered air or air conditioning, she did not know what else could be done.

Offender Robertson was received at the Darrington Unit in transit status enroute back to his unit of assignment and would have been on the outpatient mental health caseload. Offender Robertson arrived at the Darrington Unit at 6:15 a.m., which would have been one of the cooler times of day for transporting offenders from the Jester IV Unit. Based on Correctional Managed Health Care Policy Manual, B-15.2, Heat Stress, Procedures, Section VII, Transportation, there were no violations of this policy.

On May 3, 2005, I also received a message on the TDCJ mainframe, which was sent to Stephanie Zepeda by Doctor Linthicum requesting a clinical pharmacology consult in evaluating the list of medications taken by Robertson for a possible drug interaction. Doctor Linthicum provided Ms. Zepeda with a list of the medications taken by Robertson and asked Ms. Zepeda to answer a number of questions (listed below). On May 9, 2005, Ms. Zepeda provided the following answers to the questions:

1. Could any of the drugs potentiate (i.e., increase) the levels of tricyclics?

   There is potential drug-drug interaction between nortriptyline and chlorpromazine. The onset is generally delayed, severity minor, and documentation is possible. Effect-increased serum concentration of TCA. Mechanism-possibly competitive inhibition of TCA metabolism. Management-decrease TCA dose if adverse effects are seen.

2. How many of the drugs listed could affect heat regulation mechanisms?

   The most commonly used drugs that can affect thermoregulation mechanisms include antipsychotic agents (e.g., chlorpromazine), serotonin antagonists, sympathomimetic agents, and anticholinergics (e.g., benztropine).

C Lehert — Investigator's Signature
175 — ID#
6-2-05 — DATE

Chlorpromazine- May cause NMS (neuroleptic malignant syndrome), which is characterized by muscle rigidity, **hyperthermia, autonomic instability**, and altered mental status. It is also considered a "poikilothermic" (drug that may disrupt the body's normal temperature regulating mechanisms). Cases of heat stroke have been reported in the literature.

Nortriptyline- is considered a "potentiator" (drug which **may** potentiate the effects of anhidrotics or poikilothermics).

Benztropine- is considered a "anhidrotic" (drug which **may** inhibit perspiration).

3. Are there any synergistic effects from this combination of medication with respect to heat regulation?

The patient was prescribed three medications that **may** affect heat regulation: chlorpromazine, nortriptyline, and benztropine. Use of these agents concomitantly **may have additive effects on heat regulation.**

ATTACHMENTS:

1. Investigative Notes.
2. The letter from Doctor Linthicum dated May 3, 2005.
3. A copy of the e-mail message sent to Stephanie Zepeda by Doctor Linthicum dated May 3, 2005.
4. A copy of the e-mails sent and received by Stephanie Zepeda .
5. A copy of the clinical pharmacology consult completed by Ms. Zepeda dated May 9, 2005.
6. A copy of Correctional Managed Health Care Policy Manual, B-15.2, Heat Stress, Procedures, Section VII, Transportation.

CSE

C Lehert 175 6-2-05
Investigator's Signature ID# DATE

Texas Department of Criminal Justice
OFFICE OF THE INSPECTOR GENERAL

INVESTIGATIVE NOTES

TYPE OF INVESTIGATION:	CASE #:
Criminal Case Death in Custody	04-1679

4/18/2005 12:58 p.m.
I received a copy of Correctional Managed Health Care Policy Manual, B-15.2, Heat Stress, Procedures, Section VII, Transportation, from Mr. Rhoten. I was also informed that this case would be returned to me to gather more information about the medication that Robertson was taking at the time of his death, and if there was any violations committed by medical personnel. C. Eckert, # 175

4/25/2005 11:00 a.m.
I received the case from Huntsville. C. Eckert, # 175

4/25/2005 1:00 p.m.
I contacted Doctor Linthicum's office and left a message for her to call me in reference to this investigation. C. Eckert, # 175

4/26/2005 9:00 a.m.
I contacted Doctor Linthicum's office and was hold she would be in meetings all day. C. Eckert, # 175

4/26/2005 1:00 p.m.
Doctor Linthicum called me. Doctor Linthicum informed me that she was familiar with the death of Offender Ricky Robertson and that two committees had reviewed the case. Doctor Linthicum stated that the peer review and any findings or recommendations could not be released. Doctor Linthicum stated that the proceedings and findings were protected by statute from disclosure. I asked Doctor Linthicum if a letter could be written explaining what could be disclosed and any other information that could be useful to the investigation. Doctor Linthicum stated that she would provide a letter detailing what could be disclosed. I also asked Doctor Linthicum if it could be determined if the medication taken by Robertson was administered properly and in the correct dosage. Doctor Linthicum stated that she would have Stephanie Zepeda, Assistant Director of Pharmacy complete a clinical pharmacology consult on the medication taken by Robertson. C. Eckert, # 175

5/3/2005 11:00 a.m.
I received a fax from Doctor Linthicum, which was the letter that I requested. C. Eckert, # 175

INVESTIGATING OFFICER

(1) C Eckert 175 6-2-05
ID# DATE

CC-00045 (02/2005) PAGE 1

\ 0

TDCJ – Office of the Inspector General	Death in Custody
INVESTIGATIVE NOTES	CASE #: 04-1679

5/3/2005 1:22 p.m.
I received an e-mail message sent by Doctor Linthicum to Ms. Zepeda requesting a clinical pharmacology consult in evaluating the medications taken by Robertson. C. Eckert, #175

5/5/2005 8:52 a.m.
I sent Ms. Zepeda an e-mail message concerning whether she had completed the consult. C. Eckert

5/5/2005 11:00 a.m.
Ms. Zepeda sent me an e-mail message that stated that she would try to have it done today or tomorrow. C. Eckert, # 175

5/9/2005 11:56 a.m.
I received the clinical pharmacology consult from Ms. Zepeda. C. Eckert, # 175

5/10.2005 10:00 a.m.
This case was discussed with Captain Nesmith. The information provided will be supplemented to the case. C. Eckert, # 175

6/2/2005 11:00 a.m.
This case was submitted for review. C. Eckert, # 175

INVESTIGATING OFFICER

(1) C Eckert 175 6-2-05

ID# DATE

CC-00045 (02/2005)

Texas Department of Criminal Justice

Brad Livingston
Executive Director

CONFIDENTIAL

To: Dennis Rhoten
Director, Investigations
Office of Inspector General

From: Lannette Linthicum, MD, CCHP-A, FACP LL
Director, Health Services Division

Date: May 3, 2005

Re: Ricky Robertson
TDCJ #1172218 (Deceased)

The death of Offender Ricky Robertson, TDCJ #1172218 has been reviewed by two Health Care Committees of the Correctional Manage Health Care Program – namely, the Joint Morbidity and Mortality Committee and the Physician Peer Review Committee. I am not able to share with you any specific detail action taken by these committees because the proceedings and findings of these committees are protected by statute from disclosure. However, I can tell you that corrective action was recommended with respect to clinical process and care issues. I have personally met with the UTMB, Interim, Director of Mental Health Services, Dr. Pradan Nathan regarding this case. I have unequivocally expressed my concern about some clinical issues in this case. I have also expressed my desire that the corrective action outline via the Peer Review process be expeditiously completed.

I have requested that the Joint Mental Health Working Group (the latter is composed primarily of mental health staff from the three partner agencies – TDCJ, UTMB and Texas Tech) address the issue of offenders on psychotropic medications and their housing needs. The Joint Mental Health Working Group is scheduled to meet on May 19, 2005 from 1:00 p.m. – 3:00 p.m. The group will address modifying the current Health Summary for Classification form (HSM-18) to add a designator for offenders receiving psychotropic medications and instructions regarding housing considerations.

Housing considerations will be extremely limited. As you know, the Texas Department of Criminal Justice (TDCJ) does not have any tempered air or air conditioned units/facilities. There are 2,000 inpatient psychiatric beds, which are air-conditioned that serve the entire system. However, the majority of mental health offenders are outpatient and do not meet clinical criteria for inpatient care. In fact, there are approximately 17,000 offenders on the outpatient mental health caseloads. A large portion of them are receiving psychotropic medication. This issue is

P.O. Box 99
Huntsville, Texas 77342-0099
www.tdcj.state.tx.us

complex and certainly cannot be solved by the Health Services Division alone. The system has made tremendous strives in attempting to keep the unit/facility temperature at eighty-five (85) degrees as outlined in A.D. 10.64, "Temperature Extremes in the TDCJ Workplace." This has been evident in the marked reduction of heat related illnesses in offenders and staff over the past several years. Short of building new facilities with tempered air or air conditioning; I do not know what else can be done. Strict adherence to the heat directive is imperative.

I hope this satisfies your concerns. Please do not hesitate to contact me should there be any remaining outstanding issues. Thank you.

c: Owen J. Murray, DO, MBA, Medical Director, UTMB Correctional Manage Health Care
Pradan Nathan, MD, UTMB-CMHC, Interim, Mental Health Director
Colleen Eckert, Investigator III, Office of Inspector General

P.O. Box 99
Huntsville, Texas 77342-0099